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Supportive Psychotherapy: A Contradiction in Terms?

SIR: Sidney Crown (*Journal*, February 1988, **152**, 266–269) invites readers to comment on the conclusion to his paper on supportive psychotherapy that: "... if it is supportive, it cannot be psychotherapy; if it is psychotherapy, it cannot be supportive".

Dr Crown's subtitle – "a contradiction in terms" – is not the case if we move away from the relatively narrow definition of psychotherapy that has caused so much confusion and difficulty over the years. I have suggested a way out of the conceptual muddle by invoking the idea of the *psychotherapies* (Bloch, 1986). This permits us to conceive of a range of psychological treatments, each distinguishable from the others according to goals, techniques, and target of intervention. We can therefore differentiate between long-term insight-orientated individual therapy, family therapy, marital therapy, sex therapy, brief dynamic individual therapy, crisis intervention, and so forth.

Using this approach, supportive psychotherapy becomes identifiable as a separate entity with its own explicit goals, indications, and definable technical interventions. To be more specific (see Chapter 11 in Bloch (1986) for a full account of these points), supportive therapy is applied in the case of patients who are severely handicapped emotionally and interpersonally and in whom the prospect of basic change is minimal (e.g. chronic schizophrenia, chronic affective disorder, chronic neurosis, and for severe personality disorders). The chief objective of the treatment is to promote the patient's best possible psychological and social functioning by restoring and reinforcing his abilities to manage his life. Subsidiary goals include: bolstering of self-esteem; reality testing, of the patient's inherent limitations and those of treatment; forestalling relapse and deterioration; and enabling the patient to require only that degree of professional support which will result in his best possible adjustment, and so preventing undue dependency.

The components of therapy are readily definable and available for specific deployment by the therapist: reassurance, explanation, guidance, suggestion, encouragement, permission for catharsis, and affecting changes in the patient's environment. These components are brought into play within the context of a specific form of the therapist-patient relationship, typified by the therapist assuming an explicit helping role, attending to the patient's particular needs, and maintaining only a modest level of closeness.

Dr Crown refers to the alleged contradiction in terms as a paradox. In my view, the paradox revolves around the relative conceptual neglect of supportive therapy on the one hand and its implicit, widespread application in psychiatry on the other hand. Given the chronicity of a sizeable proportion of the conditions psychiatrists deal with, that level of application is much needed. Also much needed, however, is the further elaboration and refinement of the conceptual foundation upon which supportive therapy is practised.

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Reference

BLOCH, S. (1986) Supportive psychotherapy. In *An Introduction to the Psychotherapies* (ed. S. Bloch). Oxford: Oxford University Press.

SIR: The limitations of space prohibiting a point by point discussion of Dr Crown's paper, I shall touch on only three issues which I consider of importance. (I have dealt more fully with supportive psychotherapy elsewhere (Werman, 1984)).